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ABSTRACT

Under Title XXI, the State Children's Health Insurance Program (CHIP), states have considerable flexibility to define the scope of benefits available to eligible children. Noting the importance of policymakers, advocates, service providers, and parents speaking out in support of children's need for the full range of necessary health care, this issue brief provides supporting information to use in encouraging states to offer comprehensive benefit packages. The brief focuses on the services considered to be "additional" or "other" in Title XXI: (1) mental health and substance abuse services; (2) ongoing therapies and rehabilitation; (3) dental care; (4) vision services; (5) hearing services; (6) family planning; and (7) home health care. Depending on the extent of the research available on specific services, the following types of information are provided: (1) the short- and long-term effectiveness of services; (2) cost-benefit analyses of providing services; and (3) actuarial cost estimates of adding services to basic benefit packages. Also included in the brief is a delineation of the Title XXI coverage requirements for children's health insurance. The brief concludes by noting that it is critical that states designing separate children's health coverage go above and beyond the basic benefits that are required and that providing such coverage improves children's lives, avoids the needs for more costly interventions later, and is the right approach to ensure access to appropriate health care for the nation's children. (Contains approximately 30 references.) (KB)

ISSUE Brief

National Association of Child Advocates

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ENSURING CHILDREN'S ACCESS TO COMPREHENSIVE HEALTH BENEFITS: Effective Arguments for Child Advocates

By Amy Checkoway

Under Title XXI, the State Children's Health Insurance Program (CHIP), states have been given considerable flexibility to define the scope of benefits available to eligible children. Since states can choose to provide CHIP-eligible children with a spectrum of services — from access to comprehensive benefits to coverage that is considerably more restrictive — it is important that policymakers, advocates, service providers and parents speak out in support of children's need for the full range of necessary health care. The purpose of this issue brief is to give advocates supporting information that they can use to encourage their states to offer comprehensive benefit packages.

Introduction

Title XXI, the State Children's Health Insurance Program (CHIP), gives states the opportunity to expand health insurance coverage to millions of previously uninsured children. States choosing to use Title XXI funds to expand their Medicaid programs must provide the Medicaid benefit package to CHIP-eligible children. The Medicaid benefit package for children was designed for children's unique health and developmental needs, and offers regular health screening and a comprehensive range of benefits. On the other hand, states choosing to use Title XXI funds to develop a separate children's health insurance program have great flexibility in the design of the benefit package, meaning that they have the chance — or, if not designed properly, a missed opportunity — to keep children healthy and address their health concerns.

Because of concern about potential costs, states developing separate children's health insurance programs may be tempted to offer more limited benefit packages that exclude essential services or place strict and arbitrary limits on covered services. This would be unfortunate since research clearly documents the importance of comprehensive services for children's health and well-being. Furthermore, many services that are optional under Title XXI are not costly, especially when compared to the cost of not providing them.

The services at risk of being left out of state benefit packages or of being subject to limits include many critical services necessary to ensure the optimal health of children such as: mental health and substance abuse services, ongoing therapies and rehabilitation, dental care, vision services, hearing services, family planning services, and home health care. Unfortunately, comprehensive coverage of these services is not required by the Title XXI statute.

The services that are considered "additional" or "other" under Title XXI are discussed in this issue brief. Depending on the extent of the research available on specific services, the following types of information are provided: 1) the short and long-term effectiveness of services; 2) cost-benefit analyses of providing services; and/or 3) actuarial cost estimates of adding services to basic benefit packages.

Mental Health and Substance Abuse Services

An estimated 20 percent of children and adolescents, 11 million in all, have serious diagnosable emotional or behavioral disorders.[1] These children too often do not receive the mental health treatment that they need. This lack of intervention substantially interferes with or limits their ability to function in the family, school, and community. Advocates can use the following information on the importance of treatment and the cost of lack of treatment to press for the inclusion of adequate mental health and substance abuse benefits for children and adolescents.

- According to testimony before Congress by the director of the National Institute of Mental Health, children with untreated emotional and cognitive disorders are at heightened risk for school failure and dropping out, drug use, behaviors heightening their risk for HIV/AIDS, and many other difficulties.[2]
- The costs for social welfare, administration, criminal justice, and family care giving for untreated mental health needs are estimated at $4 billion per year.[3]
- In 1990, the morbidity costs (value of goods and services not produced) due to mental disorders totaled $63.1 billion.[4] Many disorders could have been alleviated with timely and appropriate treatment and support services during childhood and adolescence.

Data also shows that it is quite affordable to add these benefits to various health insurance program packages.

- According to a 1996 report by the actuarial firm Milliman & Roberts, providing significantly improved coverage for mental illnesses would increase the premium by an additional 2.5 percent per member per month. Offering coverage for both mental illnesses and substance abuse disorders would increase overall plan premiums by 3.9 percent.[5]
- A report by an independent actuarial consulting firm in Colorado determined the actuarial value of mental health services provided by the three plan options for Colorado's CHIP plan (in terms of average monthly claim costs). The average monthly claim under the Federal Employees Health Benefit Program (FEHBP) Blue Cross/Blue Shield Standard Plan coverage was found to be $6.39 per member, under the state employee coverage it was found to be $6.50, and under HMO coverage it was found to be $6.54.[6]

Title XXI Coverage Requirements for Children's Health Insurance

If states choose to use Title XXI funds to develop a separate children's health insurance program, they must choose from the following options when designing their benefit packages:

(1) one of three benchmark plans specified in the Title XXI legislation: Federal Employees Health Benefit Program (FEHBP)-equivalent children's health insurance coverage (the standard Blue Cross/Blue Shield preferred provider option service benefit plan); state employee coverage; or coverage offered by the HMO product in the state that has the largest insured commercial, non-Medicaid enrollment.

(2) a benefit package that is the actuarial equivalent of a benchmark plan. A benchmark-equivalent package is defined as: including benefits for items and services within each of the categories of "basic services;" having an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages; and having substantial actuarial value for "additional services" included in the benchmark package. "Basic services" include: inpatient and outpatient hospital services; physicians' services; laboratory and x-ray and well-baby/well-child care, including immunization services. "Additional services" include: prescription drug coverage; mental health services; and vision and dental care, if these services are covered by the benchmark package chosen by the state. If required, coverage of "additional services" must have an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in the benchmark package. States may also provide coverage for other categories of health services.

(3) coverage under an existing comprehensive state-based program in the following three states: New York, Florida, Pennsylvania.

(4) any other state-designed benefit package that is approved by the Secretary of the U.S. Department of Health and Human Services.

Ongoing Therapy and Rehabilitation

Therapies and rehabilitation services are effective in promoting children's development, speeding recovery from injury, and restoring or maintaining maximum functional capacity. Although most benefit packages being

considered by states include some coverage for therapies and rehabilitation services, these services are often subject to arbitrary limits that will not be sufficient to meet the needs of many children who require them. Advocates can use the following information about the cost-effectiveness and long-term savings of therapies and rehabilitation services to make sure that appropriate services are covered in state benefit packages and that children have access to the intensity of services that they need.

Ongoing therapies and rehabilitation services are cost-effective, especially when compared to the cost of long-term conditions resulting from lack of treatment.

- A survey conducted by the Health Insurance Association of America of its member companies found a savings of $11 for every $1 invested in rehabilitation, and a savings per claimant of between $1,500 and $250,000.[7]

Costs associated with coverage of medical rehabilitation services are small compared to potential savings.

- According to a 1990 study by Blue Cross-Blue Shield of Massachusetts, the costs of full coverage in inpatient and outpatient settings of occupational therapy, physical therapy, and speech-language pathology services amounts to 1.5 percent of the average individual monthly insurance premium, or $3.75.[8]

Dental Care

Dental care is at risk of being left out of CHIP benefit packages because of its costliness compared to other services, yet if it is not included in benefit packages, many children will go without appropriate dental care altogether. Given that children are generally healthy, for most children, dental care will be the most significant ongoing health care expense. And dental services for children are less expensive than for adults. According to a 1995 study by Milliman & Robertson, the average cost of dental services for a child is one-third the cost for a female over age 40.[9]

Advocates can use the following information about the prevalence and negative effects of tooth decay to show that the importance of dental services cannot be ignored.

- Data shows that tooth decay is the single most common chronic disease of childhood, affecting more than half of second graders[10] and more than 80 percent of 18 year olds.[11] For seven to eight year olds, this is six to eight times the frequency of asthma, which is often cited as the most common chronic disease for children.[12]
- Tooth decay is disproportionately a concern of low income children, the same children covered by CHIP. Analysis of data shows that the prevalence of tooth decay in children is inversely related to income level and that lack of dental insurance is a strong predictor of lack of dental care.[13]
- Tooth decay has been shown to result in pain, infection, dysfunction, and poor appearance and low self esteem among affected children.[14] Children who are experiencing chronic pain or are embarrassed by the appearance of their teeth may have difficultly performing at their full potential in school.

"ALTHOUGH DENTAL PROBLEMS DON'T COMMAND THE INSTANT FEARS ASSOCIATED WITH LOW BIRTH WEIGHT, FETAL DEATH OR CHOLERA, THEY DO HAVE THE CONSEQUENCES OF WEARING DOWN THE STAMINA OF CHILDREN AND DEFEATING THEIR AMBITIONS. BLEEDING GUMS, IMPACTED TEETH AND ROTTING TEETH ARE ROUTINE MATTERS ... CHILDREN GET USED TO FEELING CONSTANT PAIN. THEY GO TO SLEEP WITH IT. THEY GO TO SCHOOL WITH IT ... CHILDREN LIVE FOR MONTHS WITH PAIN THAT GROWN-UPS WOULD FIND UNENDURABLE. THE GRADUAL ATTRITION OF ACCEPTED PAIN ERODES THEIR ENERGY AND ASPIRATIONS ... MOST SHOCKING IS TO SEE A CHILD WITH AN ABSCESS THAT HAS BEEN INFLAMED FOR WEEKS AND THAT HAS SIMPLY LIVED WITH AND ACCEPTS AS PART OF THE ROUTINE OF LIFE."

– Jonathan Kozol, Savage Inequalities: Children in America's Schools.

The following information shows that preventive dental care saves money in the long run.

- It is estimated that Americans saved almost $100 billion in dental care bills during the 1980s because of the dental profession's commitment to preventive oral health measures.[15]

As noted, dental care for children comprises a significant portion of spending on children's health care. Data analyzed by the National Academy of Social Insurance showed that 23 percent of child health expenditures went to dental care.[16] Yet Medicaid EPSDT dental services are funded at only 2.3 percent of state child Medicaid dollars.[17] When adjustments are made for enrollment and utilization, 12 to 15 percent of CHIP funds may be a reasonable allocation to ensure access to a comprehensive package of essential dental benefits.[18]

Vision Services

Vision screening and eye examinations are crucial for the detection of conditions that distort children's vision and can ultimately lead to blindness if not treated properly. Visual stimuli are critical to the development of normal vision, and decreased visual acuity may contribute to inadequate school performance and more serious eye problems. In addition, children are three times as likely as adults to have acute eye problems.[19]

Advocates can use the following research on the need for and cost-effectiveness of vision services to argue for its inclusion in their state's benefit package.

- A study to estimate the prevalence of visual disorders in a group of inner-city school children found that untreated disorders were found in relatively high frequencies for this population sample. Additionally, many of the children had unidentified vision problems; eight percent of the children in the sample required glasses, yet only two percent were actually wearing them. Of the children who had previously received care, many of the children had lost their glasses and could not afford a replacement.[20]
- Studies which include children and adolescents have estimated that routine eye care would achieve annual savings exceeding $100 million.[21]

Hearing Services

Ear infections are one of the most common diagnoses among all age groups of children; for example, in 1988, an estimated 5.9 million preschool children had recurrent ear infections.[22]

ACCORDING TO THE AMERICAN OPTOMETRIC ASSOCIATION, NEARSIGHTEDNESS AFFECTS ABOUT THREE PERCENT OF FIVE TO NINE YEAR OLDS; EIGHT PERCENT OF TEN TO TWELVE YEAR OLDS; AND 16 PERCENT OF TEENAGERS. THE ASSOCIATION ESTIMATES THAT ONE OUT OF EVERY EIGHT CHILDREN AGES FIVE TO TWELVE WEARS EYEGLASSES (12.5 PERCENT).

– American Optometric Association, "School-Aged Children's Eye Health and Eyesight." Writer's Resource newsbrief (1991).

Advocates can use the following information on the effectiveness and cost of treatment to emphasize the importance of including hearing services in benefit packages for children.

If children receive the appropriate hearing services early in life, they are less likely to need more costly care later on.

- In a screening conducted at Kaiser Permanente Medical Center in Hawaii on more than 10,000 infants born between 1992 and 1997, only 15 of the 415 infants who failed the initial hearing tests and received hearing aids before six months of age were identified at a follow-up test as needing further intervention.[23] The provision of aids for these children before six months of age averted the need for more costly interventions later and optimized speech and language development.[24]
- A University of Colorado study reveals that children receiving hearing intervention by the age of three months perform significantly higher at 40 months than those who are identified later.[25]

Preventive hearing care is not expensive compared to the cost savings that accompany early detection and subsequent treatment of children with hearing loss.

- In a preliminary report of a statewide program of universal newborn hearing screening, the average cost of a screening test was $25.[26] This cost is a reasonable investment, especially when compared to the potential negative effects associated with undetected hearing loss.

CHILDREN ARE 20 TIMES MORE LIKELY TO HAVE ACUTE EAR INFECTIONS THAN ADULTS, AND PERSISTENT INFECTIONS CONTRIBUTE SIGNIFICANTLY TO THE INCREASING NUMBER OF INFANTS WHO DEVELOP HEARING LOSS IN LATER LIFE.

— American Academy of Pediatrics, "Recurrent Ear Infections on Increase for U.S. Children," Pediatrics (February 1998).

Family Planning Services

The provision of family planning services for adolescents is sometimes controversial, but critical to prevent the many poor outcomes — for both teen mothers and their children — associated with teen pregnancy and parenting. Many adolescent mothers are unable to escape a life of poverty; data show that almost half of all teenage mothers and over three-fourths of unmarried teen mothers began receiving public assistance within five years of the birth of their first child.[27] The cost of teen births is not limited to public assistance payments; early childbearing also represents significant medical risks for teens and the infants themselves. Teen mothers are less likely to receive prenatal care, and their children are at higher risk of low birth weight and future hospitalization or death in infancy.[28]

Providing access to family planning services reduces the amount of money that states will have to spend on direct and related social services, a powerful argument that advocates can use for inclusion of these services in benefit packages.

- The Alan Guttmacher Institute estimated that for every dollar spent for contraceptive services to women of all ages,

$4.40 is saved that would otherwise be needed for medical care, welfare, and nutrition programs just in the two years following a birth.[29]

- A recent study found that teen childbearing costs taxpayers $6.9 billion per year — $2,831 per year per teen mother.[30]
- According to the American Journal of Public Health, the cost for one year of a contraceptive pill for a woman enrolled in managed care is $422, compared to $5,512 in prenatal care and delivery for each unintended pregnancy carried to term.[31]

Home Health Care

Rising medical costs are compelling doctors, hospitals, and insurers to minimize the amount of time that patients spend in expensive hospital beds or to keep them out of the hospital altogether. New technologies and advances in medicine make home health care one of the fastest-growing service industries, with home care for infants and children expanding the fastest.[32]

Home care is not expensive compared to the cost of institutional care. For many conditions, home health costs are one half to one third — sometimes as little as one tenth — of costs for comparable hospital care. Advocates can use the following research about the low cost of home care compared to institutional care to encourage their state to include home care services in benefit packages.

- According to a study by the National Association for Home Care, caring for a baby with breathing and feeding problems costs approximately $60,900 per month in a hospital compared to $20,200 per month at home.[33]
- A study on the costs of care for ventilator assisted children found that hospital charges exceeded home costs by $793 per day, on average.[34]
- A study of comparative charges for home versus hospital administration of intravenous antibiotics found that average home charges were $207 per day compared with hospital charges of $428 per day.[35]

Although home care is often considerably less costly for children than hospital care, the financial burden on families is still enormous for the small population of children with home health care needs. According to one study, nursing and physician costs are by far the largest costs associated with home care, accounting for 64 percent of all costs, with equipment rentals, materials, and drugs accounting for most of the rest.[36] The structure of home care benefits under CHIP needs to be flexible enough to meet the needs of children with a variety of conditions and resources who can be cared for at home.

Conclusion

The State Children's Health Insurance Program (CHIP) provides states with an important opportunity to ensure that children have the comprehensive health coverage that they need. Evidence presented in this issue brief suggests how critical it is that states designing separate children's health insurance programs go above and beyond the basic benefits that are required. Services that are considered "additional" or "other" under the Title XXI statute need to be thought of as absolutely essential. The provision of comprehensive services improves the lives of children, avoids the need for more costly interventions later, and is the right approach to ensure access to appropriate health care for our nation's most vulnerable population — our children.

Resources

Although this list of resources is by no means all-inclusive, it should serve as a good starting point for additional information related to the importance of comprehensive benefit packages for children.

Available from the National Association of Child Advocates, 1522 K Street, NW, Suite 600, Washington, DC 20005, 202-289-0777.

- *The State Children's Health Insurance Program: Is Your State Making the Best Choices for Children?* (February 1998).
- *Good Ideas From State Plans: State Health Plan Provisions That Can Benefit Children* by the Center on Budget and Policy Priorities, Children's Defense Fund, Families USA, Family Voices, National Association of Child Advocates, and National Association of Children's Hospitals (May 1998).

Available from the American Academy of Pediatrics, Department of Government Liaison, 601 13th Street, NW, Suite 400 North, Washington, DC 20005, 202-347-8600.

- *Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years* (RE9730) (December 1997). The Academy's recommended comprehensive benefit package developed by the Committee on Child Health Financing.
- *American Academy of Pediatric Dentistry's Fact Sheet on Children's Dental Care in SCHIP.*

Available from the American Dental Association, 211 East Chicago Avenue, Chicago, IL 60611-2678, 312-440-7494.

- *The Role of Dentistry in the State Children's Health Insurance Program.*

Available from the Children's Defense Fund, 25 E Street, NW, Washington, DC 20001, 202-628-8787.

- *An Advocate's Tool Kit for the State Children's Health Insurance Program* by Stan Dorn, Martha Teitelbaum, and Corina Cortez.

Available from Families USA, 1334 G Street, NW, Washington, DC 20005, 202-628-3030.

- *A Preliminary Guide to Expansion of Children's Health Coverage* (September 1997 — updated January 1998).

Available from the Maternal and Child Health Policy Research Center, Fox Health Policy Consultants, 750 17th Street, NW, Suite 1025, Washington, DC 20006-4607, 202-223-1500.

- *Plan and Benefit Options Under the State Children's Health Insurance Program* by Harriette B. Fox with Margaret A. McManus, Regina R. Graham, and Ruth A. Almeida.

Available from the National Health Law Program, 211 North Columbia Street, 2nd Floor, Chapel Hill, NC 27514, 919-968-6308.

- *EPSDT Update for Child Health Insurance and Medicaid Advocates prepared* by Jane Perkins, Lourdes Rivera, and Kristi Olson of the National Health Law Program and Abigail English and Catherine Teare of the National Center for Youth Law (November 20, 1997).

Endnotes

1. Institute of Medicine, *Research on Children and Adolescents with Mental, Behavioral, and Developmental Disorders: Mobilizing a National Initiative* (Washington, DC: National Academy of Sciences Press, 1989).
2. S. Hyman, Director of the National Institute for Mental Health (NIMH), Testimony on Children's Health before Appropriations Subcommittee on Labor, Health, and Human Services and Education, Washington, DC: 29 October 1997.
3. Rice and Miller, "The Economic Burden of Affective Disorders," *Advances in Health Economics and Health Services Research* 14 (1993): 37-53.
4. Ibid.
5. Milliman and Robertson, "The Costs of Non-Discriminatory Health Insurance Coverage for Mental Illness: An Analysis of S. 298, the 'Equitable Health Care for Severe Mental Illness Act' and the Watson Wyatt Worldwide Cost Analysis of S. 298," (1996).
6. Colorado Health Plan Plus, Appendix, October 1997.
7. American Occupational Therapy Association, Inc. "Health Care Reform and Occupational Therapy" Fact Sheet.
8. Blue Cross and Blue Shield Association, Washington, DC, 1990.
9. Milliman and Robertson, *Dental Cost Guidelines*, 1995.
10. J.A. Brunelle, "Caries Attack in the Primary Dentition of U.S. Children," Abstract 575, *J. Dent Res 69* (special issue) 180, (1990).
11. Washington, DC: U.S. Government Printing Office, *Oral Health of U.S. Children, National and Regional Findings*, 1989.
12. B. Edelstein, "Fact Sheet on Children's Dental Care in CHIP," American Academy of Pediatrics, 1998.
13. Ibid.
14. Ibid.
15. American Dental Association, "The Role of Dentistry in the State Children's Health Insurance Program," 1998.
16. A. Evans and R.B. Friedland, "Financing and Delivery of Health Care for Children," Background paper for the NASI Advisory Committee on Reforming American Health Care Financing Policy and Administrative Choices, National Academy of Social Insurance, May 1994.
17. American Academy of Pediatrics' annual analysis of HCFA 2082 data.
18. B. Edelstein, "Fact Sheet on Children's Dental Care in CHIP," American Academy of Pediatrics, 1998.
19. Health Insurance Association of America, *Source Book of Health Insurance Data: 1996, 1997.*
20. M.W. Preslan and A. Novak, "Baltimore Vision Screening Project," *Opthamology 105* (1) (Jan 1998): 105-109.
21. Ackerman, "Benefits of Preventive Programs in Eye Care are Visible on the Bottom Line," *Diabetes 15* (April 1992): 580.
22. American Academy of Pediatrics, "Recurrent Ear Infections on Increase for U.S. Children," *Pediatrics* (February 1998).
23. American Academy of Pediatrics, "Newborn Hearing Screening Impacts Speech and Language Development," *Pediatrics* (February 1998).
24. M.P. Downs, "Universal newborn hearing screening — The Colorado story," *International Journal of Pediatric Otorhinolaryngology* 32 (1995): 257-259.
25. Ibid.
26. Ibid.
27. Washington, DC: U.S. Congressional Budget Office, *Sources of Support for Adolescent Mothers*, September 1990.
28. Center for Population Options, *Teenage Pregnancy and Too-Early Childbearing: Public Costs, Personal Consequences*, 6th edition, (Washington, DC: Center for Population Options, 1992).
29. Forrest, J.D. and Singh, S., "Public-Sector Savings Resulting from Expenditures for Contraceptive Services," *Family Planning Perspectives*, 22 (1), (1990).
30. R.A. Maynard (ed.), *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*, (Washington, DC: Urban Institute Press, 1997).
31. T. Lewin, "Effort to Cover Contraception Likely to Fail," *New York Times*, 1 February 1998.
32. S. Findlay, "There's No Place Like Home," *U.S. News & World Report*, 25 January 1998.
33. Ibid.
34. D. Dranove, "What Impact Did the Programs Have on the Costs of Care for Ventilator Assisted Children?" *Pediatric Home Care* (1988).
35. L.F. Harris, T.F. Buckle, and F.L. Coffey, "Intravenous Antibiotics at Home," *Southern Medical Journal*, 79(2), (February 1986).
36. D. Dranove, "What Impact Did the Programs Have on the Costs of Care for Ventilator Assisted Children?: Pediatric Home Care (1988).

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